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# 7 QUESTIONS YOU SHOULD ASK ABOUT YOUR MANAGED CARE PROGRAM

DEDICATED TO GOVERNMENT HEALTH PROGRAMS



As more states move their Medicaid populations into managed care, it is important that states monitor their managed care organizations (MCOs).

Lawmakers, oversight agencies, and taxpayers are demanding predictable health care outcomes based on cost effective delivery services.

## Risk Mitigation:

- Ineffective Contract Provisions
- Overpayment of Capitated Payments
- Misstated MLR Calculation
- Overstated Capitated Rate
- Non-Compliance with Contract Performance Requirements

Insurance-based Cost Structure can lead to misunderstanding of the need for monitoring MCOs because in some instances, states have limited their short-term cost exposure to the capitation payment made to the MCOs.

Oversight and monitoring plans must include activities to monitor MCO Performance and ability to control costs, as well as activities that can quickly identify and resolve current service delivery problems, and quantify and prevent inappropriate payments.



## 7 Questions you should ask about your Managed Care Program:

1. Are you prepared to implement or renew your managed care contracts?
2. Do you have a system in place to make sure your health plans are paid correctly?
3. Do you have processes in place to ensure your health plans are paying providers appropriately?
4. Are you confident your health plans are complying with contractual requirements?
5. Do you have a system to help you evaluate the effectiveness of your managed care program?
6. Does your Medicaid program leverage innovative federal funding opportunities?
7. Has your state developed systems to prevent and/or detect fraud, waste or program abuse?





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# 7 QUESTIONS YOU SHOULD ASK YOURSELF ABOUT YOUR MANAGED CARE PROGRAM



# **1. Are you prepared to implement or renew your managed care contracts?**

Poor implementation of managed care can result in a myriad of significant issues, and ultimately, may have a negative impact on the health of the very members the program is designed to protect.

Strong contracts and program management are essential in helping states meet their fiscal responsibility to control costs and ensure program performance compliance with contracts that benefit one of the most vulnerable populations in the state and are generally some of the largest third-party contracts entered into by the state.



# 1. Are you prepared to implement or renew your managed care contracts?

## Risks:

- Contract considerations for all plan benefits.
- Lack of robust managed care contracts to enable effective monitoring.
- Non-targeted stakeholder outreach.
- Ineffective health plan implementation readiness.
- Non-consideration of health plan audit strategies.
- Other program-specific considerations.





# 1. Are you prepared to implement or renew your managed care contracts?

## Best Practices:

- Obtain program benefit design consulting services (carve in/carve out).
- Utilize implementation process/timeline management.
- Obtain resource support, including subject matter expertise.
- Conduct review of health plan contract development.
- Conduct health plan and health plan system readiness reviews.
- Develop stakeholder outreach plan and implementation guide, including liaison to provider associations, legislative advocacy groups or other outreach, as appropriate.
- Conduct a program risk assessment and evaluation.
- Develop a comprehensive monitoring plan including reporting requirements and other program management tools.
- Conduct MMIS readiness testing.

## **2. Do you have a system in place to make sure your health plans are paid correctly?**

A comprehensive proactive monitoring program is vital to ensuring:

- Data generated and used by your managed care program is complete and accurate.
- Costs reported are accurate and allowable.
- Operations are meeting contract performance standards.

The most successful states create online reporting systems for MCOs to report data, allowing the state to conduct further data analysis on the information provided.

Successful overall monitoring program provides an incentive for MCOs to perform at a high standard.

## **2. Do you have a system in place to make sure your health plans are paid correctly?**

### **Risks:**

- Lack of clear contractual requirements.
- Lack of adequate guidance for MCOs to ensure their reporting is accurate, complete and consistent.
- No provisions for periodic MCO submission of data in a prescribed format to the state.
- Failure to consider implementation of regular monitoring programs.



## **2. Do you have a system in place to make sure your health plans are paid correctly?**

### **Best Practices:**

- Clear definition of cost principles.
- Treatment of third-party recoveries, reinsurance recoveries and pharmacy rebates.
- Provisions for retention and submission of data.
- Provisions for state's right to audit.
- Provisions for addressing non-compliance.
- Provisions for addressing overpayments and excess profits.
- Process for capitation payment testing.
- Provisions for data analysis and encounter testing.



### **3. Do you have processes in place to ensure your health plans are paying providers appropriately?**

The most successful states have a system for periodic submission of data in a prescribed format and they have implemented a regular monitoring program.

**Annual, quarterly, bi-monthly, or even monthly audits can identify:**

- Inaccurate encounter data.
- Overpayment of medical costs.
- Overpayment of administrative costs.

Audits can provide a real and substantial benefit to a state's Medicaid agency by ensuring limited funds aren't being distributed improperly.



### **3. Do you have processes in place to ensure your health plans are paying providers appropriately?**

#### **Risks:**

- Overpayment of capitated payments:
  - ❖ Ineligible enrollees
  - ❖ Missing encounters
  - ❖ Inflated encounters
  - ❖ Duplicates
- Impact on capitated rates from:
  - ❖ Overpayment of medical expenses
  - ❖ Overpayment of administrative expenses
- Impact on service delivery:
  - ❖ Compliance with MLR regulations



### **3. Do you have processes in place to ensure your health plans are paying providers appropriately?**

#### **Case Study 1**

A recent state Legislative Auditor audit of the state's managed care organization program found the state paid **\$1.85 million** for Medicaid health insurance coverage **for more than 1,700 dead people during a 16-month period**. The auditor's office stated the health agency did not have a sufficient process in place for timely identifying deceased Medicaid participants. The legislative auditor compared payments made through the programs to death records in the state health agency's Center of State Registrar and Vital Records.



### **3. Do you have processes in place to ensure your health plans are paying providers appropriately?**

#### **Case Study 2**

A recent audit by the state Comptroller of a state's capitation payments found duplicate capitation payments made to slightly different names (***Robert Jones; Rob Jones; Baby Boy Jones***) with no SSN under different addresses and different patient IDs. For the three-year period they identified over **\$53 million** in improper Medicaid payments for recipients who had multiple identification numbers.



### **3. Do you have processes in place to ensure your health plans are paying providers appropriately?**

#### **Case Study 3**

A recent audit of one state's MCO program found potential **overpayments of \$17.5 million** by two MCOs to providers that inflated the capitation rate resulting in over **\$22.5 million** of potential overpaid capitation payments to the state's MCOs for the year.



### **3. Do you have processes in place to ensure your health plans are paying providers appropriately?**

#### **Best Practices:**

- Reconcile and validate submitted encounters to financial documents.
- Review and validate member enrollment data for on-going accuracy.
- Audit medical and administrative costs.
- Provisions for recovery of overpayments.
- Actuarial review to coincide with any rate adjustments.





## **4. Are you confident your health plans are complying with contractual requirements?**

Failure to provide enrollees with the necessary services expected and required under their contracts is one of the biggest risks of any Medicaid managed care program.

This is the public's biggest concern with moving to managed care.

If your state relies on the MCO or Medicaid Fiscal Intermediary to monitor and address contract non-compliance and poor performance, you're risking the state's most vulnerable population and your program's reputation.

The most successful states conduct risk assessments at the start of their monitoring programs and then update the risk assessments every year or every other year.



## **4. Are you confident your health plans are complying with contractual requirements?**

### **Risks:**

- Inaccurate self reporting of performance according to the terms of its contract.
- Complex organizational structure and myriad of related party contracts used by many MCOs.
- Inadequate network coverage.
- Inadequate access to care provisions.
- Inaccurate provider directories that reflect actual experience.
- Untimely and inadequate call center operations.
- Low member and provider satisfaction.
- Inadequate information technology (IT) security systems to protect personal health information (PHI).
- Lack of timely and comprehensive claims processing complaint handling.



## **4. Are you confident your health plans are complying with contractual requirements?**

### **Best Practices:**

- Comprehensive Risk Assessment of each MCO contract.
- Performance audits to test for compliance with contract performance provisions.
- Follow-up audits to validate correction of issues.
- HIPAA compliance reviews and SSAE 16 audits to test for compliance with HIPAA laws and security of IT systems.
- Benefit administration reviews.
- Actuarial reviews.

## **5. Do you have a system to help you evaluate the effectiveness of your managed care program?**

Implementing a Data Collection and Maintenance System and On-Going Monitoring Program can ensure you have the data to respond to Program Evaluation inquiries.

- States should be able to document they are achieving the results it sought by outsourcing with the MCO.
- States should conduct cost comparison analysis with FFS programs.



## **5. Do you have a system to help you evaluate the effectiveness of your managed care program?**

### **Risks:**

- Inability to account for and report cost benefit of programs.
- Inability to analyze cost trends
- Inability to analyze service delivery
  - Contract compliance
  - Customer Service
  - Denial of services





## **5. Do you have a system to help you evaluate the effectiveness of your managed care program?**

### **Best Practices:**

- Data compilation systems to facilitate cost benefit analysis.
- Performing audits and analysis that go beyond the scope of external quality reviews (EQR) to ensure MCOs provide beneficiaries with access to services to which they are entitled.
- Audits focus on services that are denied by MCOs, ensuring beneficiaries are given appropriate rights to obtain services through a review of samples of targeted cases to identify instances of non-compliance.
- Perform clinician reviews to assist with evaluating the effectiveness of health plan quality improvement and member education initiatives.

## **6. Does your Medicaid program leverage innovative federal funding opportunities?**

**Many states are taking advantage of opportunities through the CMS Innovation Center, which oversees:**

- Delivery system reform incentive payments (DSRIP).
- State innovation models (SIM).
- Other strategies available through an 1115 waiver.

DSRIP, SIM and other forms of quality improvement (QI) models typically include incentive-based payments to eligible providers that undertake intensive delivery system reform initiatives where payments are based on the achievement of quality measures.



## **7. Has your state developed systems to prevent and/or detect fraud, waste or program abuse?**

Managed care programs are designed to help beneficiaries have access to the care they need.

States should have a strategy to identify, detect and prevent fraud, waste and abuse within managed care.

A comprehensive data analytics fraud risk assessment of a managed care program can:

- ❖ Identify vulnerabilities.
- ❖ Identify outlier populations to help states determine where to focus scarce program integrity resources.



## **7. Has your state developed systems to prevent and/or detect fraud, waste or program abuse?**

### **Risks:**

- Outliers with medical and drug utilization.
- Improper payments made by MCOs to providers.
- Duplicate payments between benefit programs.
- Inappropriate payments to MCOs.
- Improper coding of data used to risk adjust payments.
- Overpayments made to health plans through capitation payment errors and/or administrative cost overpayments.



## **7. Has your state developed systems to prevent and/or detect fraud, waste or program abuse?**

### **Best Practices:**

- Establishing an agency program integrity group with the ability to define return on investment (ROI) within managed care (OIG, MFCU).
- Audits to ensure that your MCOs have implemented and are effectively operating PI units that identify and recover overpayments associated with fraud, waste and abuse (FWA).
- Claims analysis.
- Assessment of FWA Detection Program.
- Program Integrity Contract Provision Review.

# Timing of Reviews under a Comprehensive Monitoring Program

## Best Practices:

- Risk Assessments – Bi-Annual Basis.
- Encounter Data Reconciliation – Monthly or Bi-Monthly.
- Encounter Validation – Annual.
- Enrollment Data Validation – Annual.
- Financial Reviews - Medical and Administrative Cost and Recoveries Audits – Quarterly &/or Annual.
- Performance Audits – Rotating Basis every two years.
- Follow-up Audits – As needed, depending on severity of findings.
- IT Security Reviews - HIPPA Compliance and SSAE 16 Audits – Annually.
- Benefit Administration Reviews – “As-Needed” Basis.
- Actuarial Reviews – Coincide with Periodic Rate Adjustments.



## Summary – Greater National Focus on Oversight of Managed Care Programs

GAO identified a gap in state and federal efforts to ensure Medicaid managed care program integrity. (May 2014 review GAO-14-341)

Federal laws require the states and CMS to ensure the integrity of the Medicaid program, including payments under Medicaid managed care.

State PI units and MFCU included in GAO's review said they primarily focus their efforts on Medicaid FFS claims and have not begun to closely examine program integrity in Medicaid managed care. In addition, federal entities have taken few steps to address Medicaid managed care program integrity.

- CMS largely delegated managed care program integrity oversight activities to the states, but has not updated its program integrity guidance since 2000.
- CMS does not require states to audit managed care payments.
- State officials require additional CMS support, such as additional guidance and the option to obtain audit assistance from existing Medicaid integrity contractors in overseeing Medicaid managed care program integrity.

## Summary – Greater National Focus on Oversight of Managed Care Programs

National Association of Medicaid Directors (NAMD) Letter/Presentation to the Centers for Medicare and Medicaid Services (CMS) – (September 2014)

Medicaid Managed Care Modernization: Employing New Tools and Efficiencies to Strengthen Program Integrity”

CMS must do more to keep pace with the evolving delivery model and new tools used in the managed care environment through on-going partnership with states.

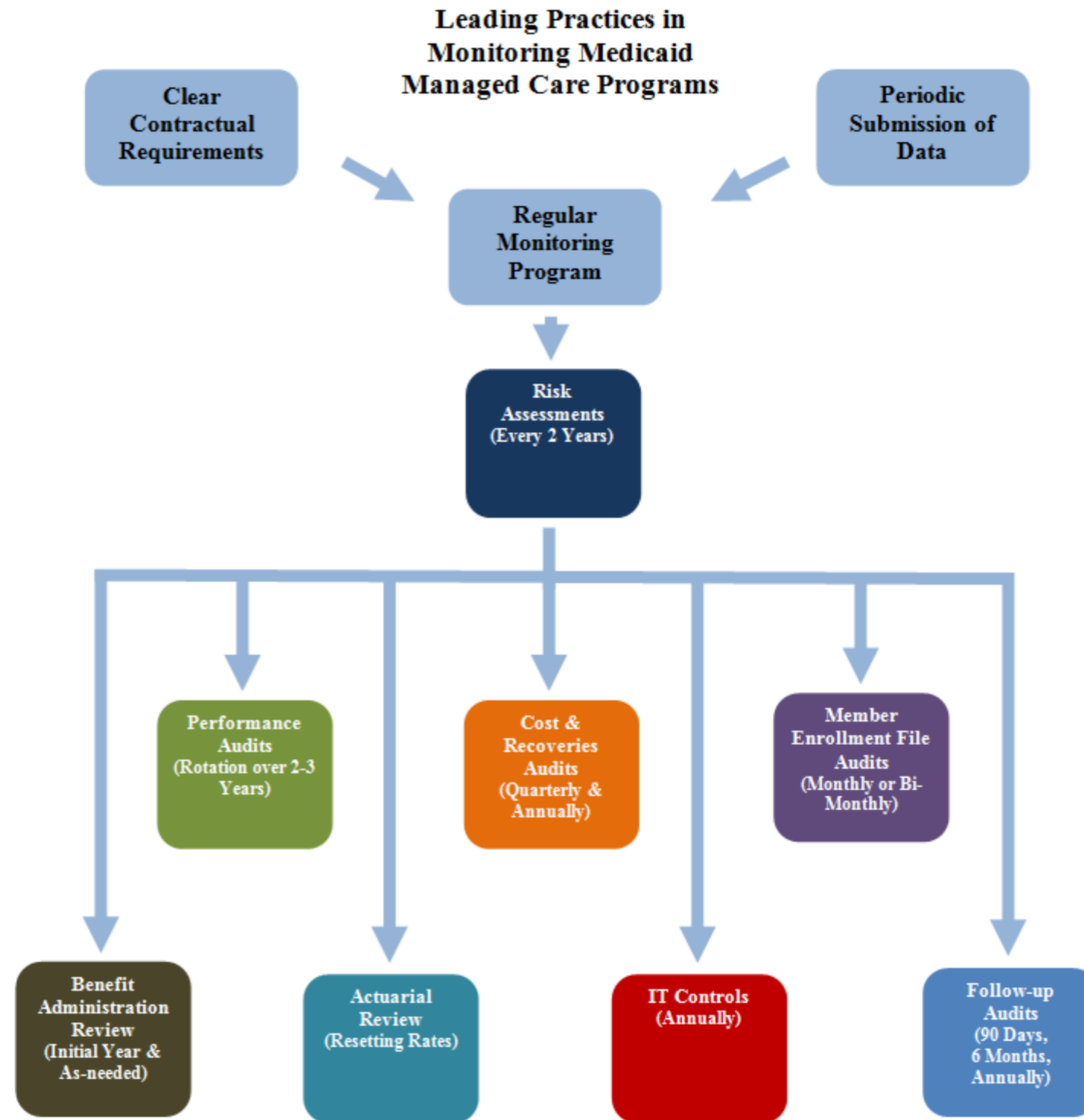
Recommendations to help improve the effectiveness and efficiency of Medicaid managed care programs:

- Provider Enrollment
- Encounter and Claims Data
- Compliance and Staffing
- Coordination of Benefits



# Summary

- Risk to Capitated Rate Computation**
  - Overpayment of Medical Costs
  - Overpayment of Administrative Costs
  - Unallowable Costs
  - Unreported Recoveries
- Risk to MLR Cost Compliance**
  - Underserved Medicaid Population
- Risk of Excessive Capitated Payments**
  - Inaccurate Encounter Data
  - Ineligibles
  - Duplicates
- Risk to Operational Performance & Contract Compliance**
  - Network Coverage
  - Access to Care
  - Call Center Operations
  - Timeliness of Claims Processing
  - Enrollee Complaints





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**Questions?**